

Facility Services

This section contains payment policies and information for facility services.

All providers must follow the administrative rules, medical coverage decisions and payment policies contained within the Medical Aid Rules and Fee Schedules, Provider Bulletins, and Provider Updates. If there are any services, procedures, or text contained in the CPT[®] and HCPCS coding books that are in conflict with the Medical Aid Rules and Fee Schedules, the department's rules and policies apply (WAC 296-20-010). All policies in this document apply to claimants receiving benefits from the State Fund, the Crime Victims Compensation Program and Self-Insurers unless otherwise noted.

Questions may be directed to the Provider Hotline at 1-800-848-0811.

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HOSPITAL PAYMENT POLICIES

HOSPITAL PAYMENT POLICIES OVERVIEW

Hospital payment policies established by the department are reflected in Washington Administrative Code **Chapters 296-20, 296-21, 296-23, 296-23A**, Provider Bulletin 01-13, and the Hospital Billing Instructions.

The Washington State Department of Labor and Industries, or Self-Insured employer, will pay for the costs of proper and necessary hospital services associated with an accepted industrial injury. No co-payments or deductibles are required or allowed from injured workers.

HOSPITAL BILLING REQUIREMENTS

All charges for hospital inpatient and outpatient services provided to injured workers must be submitted on the UB-92 billing form following the **UB-92 National Uniform Data Element Specifications**.

Hospitals are responsible for establishing criteria to define inpatient and outpatient services.

All inpatient bills will be evaluated according to the department's Utilization Review Program.

Inpatient bills submitted without a treatment authorization number may be selected for retrospective review.

See www.lni.wa.gov/hsa for the most current Hospital Billing Instructions.

HOSPITAL INPATIENT PAYMENT INFORMATION

State Fund

Services for hospital inpatient care provided to injured workers covered by the State Fund are paid using three payment methods:

1. An All Patient Diagnosis Related Group (AP-DRG) system. See WAC 296-23A-0470 for exclusions and exceptions. The current AP-DRG Grouper version is 14.1.
2. A statewide Per Diem rate for those AP-DRGs that have low volume or for inpatient services provided in Washington rural hospitals.
3. Percent-of Allowed Charges (POAC) for hospitals excluded from the AP-DRG system.

The following table provides a summary of how the above methods are applied.

| Hospital Type or Location | Payment Method for Hospital Inpatient Services |
|---|--|
| Hospitals not in Washington | Paid by an Out-of-State POAC factor. Effective July 1, 2002 the rate is 64.2% . |
| Washington Excluded Hospitals: <ul style="list-style-type: none"> ● Children’s Hospitals ● Health Maintenance Organizations (HMOs) ● Military Hospitals ● Veterans Administration ● State Psychiatric Facilities | Paid 100% of allowed charges. |
| <ul style="list-style-type: none"> ● Washington Rural Hospitals [Department of Health (DOH) Peer Group 1] | Paid using Washington state-wide per diem rates for designated AP-DRG categories, including: <ul style="list-style-type: none"> ● Chemical dependency ● Psychiatric ● Rehabilitation ● Medical and ● Surgical. |
| All other Washington Hospitals | Paid on a per case basis for admissions falling within designated AP-DRGs. For low volume AP-DRGs, Washington hospitals are paid using the statewide per diem rates for designated AP-DRG categories, including: <ul style="list-style-type: none"> ● Chemical dependency ● Psychiatric ● Rehabilitation ● Medical and ● Surgical See www.lni.wa.gov/hsa for the current AP-DRG list and assignments. |

Hospital Inpatient AP-DRG Base

Effective **July 1, 2002** the AP-DRG Base Rate is **\$7,151.25**.

The AP-DRG Assignment list with AP-DRG codes and descriptions and length of stay is in the Fee Schedules section and online at www.lni.wa.gov/hsa.

Hospital Inpatient AP-DRG Per Diem Rates

Effective July 1, 2002 the AP-DRG Per-Diem Rates are as follows:

| PAYMENT CATEGORY | RATE* | DEFINITION |
|-------------------------------------|--|--------------------------------|
| Psychiatric AP-DRG Per Diem | <u>\$865.60</u> Multiplied by the number of days allowed by the department. Payment will not exceed allowed billed charges. | AP-DRG Numbers 424-432. |
| Chemical Dependency AP-DRG Per Diem | <u>\$660.62</u> Multiplied by the number of days allowed by the department. Payment will not exceed allowed billed charges. | AP-DRGs Numbers 743-751. |
| Rehabilitation AP-DRG Per Diem | <u>\$1,266.87</u> Multiplied by the number of days allowed by the department. Payment will not exceed allowed billed charges. | AP-DRG Number 462. |
| Medical AP-DRG Per Diem | <u>\$1,445.41</u> Multiplied by the number of days allowed by the department. Payment will not exceed allowed billed charges. | AP-DRGs identified as medical |
| Surgical AP-DRG Per Diem | <u>\$2,185.97</u> Multiplied by the number of days allowed by the department. Payment will not exceed allowed billed charges. | AP-DRGs identified as surgical |

For information on how specific rates are determined see Chapter 296-23A in the Medical Aid Rules and Fee Schedules.

Additional Hospital Inpatient Rates

| PAYMENT CATEGORY | RATE | DEFINITION |
|---|--|---|
| Transfer-out Cases | <p>Unless the transferring hospital's charges qualify for low outlier status, the stay at this hospital is compared to the AP-DRG's average length of stay.</p> <p>If the patient's stay is less than the average length of stay, a "per-day rate" is established by dividing the AP-DRG payment amount by the average length of stay for the AP-DRG. Payment for the first day of service is two times the "per-day rate." For subsequent allowed days, the basic per-day rate will be paid.</p> <p>If the patient's stay is equal to or greater than the average length of stay, the AP-DRG payment amount will be paid.</p> | A transfer is defined as an admission to another acute care hospital within 7 days of a previous discharge. |
| Low Outlier Cases (costs are less than the threshold) | Hospital Specific Percent of Allowed Charge (POAC) Factor multiplied by allowed billed charges. | Cases where the cost* of the stay is less than ten percent (10%) of the statewide AP-DRG rate or \$ 500.00, whichever is greater. |
| High Outlier Cases (costs are greater than the threshold) | AP-DRG payment rate plus 100% of costs in excess of the threshold. | Cases where the cost* of the stay exceeds \$12,000.00 or two standard deviations above the statewide AP-DRG rate, whichever is greater. |

*Costs are determined by multiplying the allowed billed charges by the hospital specific POAC factor.

Self-Insured

Services for hospital inpatient care provided to injured workers covered by self-insured employers are paid using a hospital-specific POAC factor. See WAC 296-23A-0210.

Crime Victims

Services for hospital inpatient care provided to crime victims covered by the Crime Victims Compensation Program are paid using Medicaid POAC factors. See WAC 296-30-090.

HOSPITAL OUTPATIENT PAYMENT INFORMATION

Services for hospital outpatient care provided to injured workers covered by the State Fund are paid using three payment methods:

1. Ambulatory Payment Classification (APC) system. See WAC 296-23A Section 4, and Provider Bulletin 01-13 for a description of the department's APC system.
2. An amount established through the department's Professional Services Fee Schedule for items not covered by the APC system.
3. Percent of Allowed Charges (POAC) for hospital outpatient services not paid by either the APC system or with an amount from the Professional Services Fee Schedule.

The following table provides a summary of how the above methods are applied.

| Hospital Type or Location | Payment Method, Hospital Outpatient Services |
|---|---|
| Hospitals not in Washington | Paid by an Out-of-State POAC factor. Effective July 1, 2002 the rate is 64.2% . |
| Washington Excluded Hospitals: <ul style="list-style-type: none"> ● Children's Hospitals ● Military Hospitals ● Veterans Administration ● State Psychiatric Facilities | Paid 100% of allowed charges. |
| <ul style="list-style-type: none"> ● Rehabilitation Hospitals ● Cancer Hospitals ● Rural Hospitals (DOH Peer Group 1) ● Critical Access Hospitals ● Private Psychiatric Facilities | Paid a facility-specific POAC |
| All other Washington Hospitals | Paid on a per APC basis for services falling within designated APCs. For non-APC paid services, Washington hospitals are paid using an appropriate Professional Services Fee Schedule amount, or a facility-specific POAC*. |

*Hospitals will be sent their individual POAC and APC rate each year.

Self-Insured

Services for hospital outpatient care provided to injured workers covered by self insured employers are paid using facility-specific POAC factor or the appropriate Professional Services Fee Schedule amount, (see WAC 296-23A-0221).

Crime Victims

Services for hospital outpatient care provided to crime victims covered by the Crime Victims Compensation Program are paid using either Medicaid POAC factors or the Professional Services Fee Schedule amount, (see WAC 296-30-090).

Note: HCPCS code Q0081 listed as non-covered in the fee schedule will be covered for hospitals until the Centers for Medicare and Medicaid Services (CMS) issues a more appropriate code.

AMBULATORY SURGERY CENTER (ASC) PAYMENT POLICIES

Information about the department's requirements for ASCs can be found in WAC 296-23B and Provider Bulletin 01-12. These are available online at <http://www.lni.wa.gov/hsa>.

ASC SERVICES INCLUDED IN THE FACILITY PAYMENT

Facility payments for ASCs include the following services, which are not paid separately:

- Nursing, technician and related services.
- Use by the recipient of the facility, including the operating room and the recovery room.
- Drugs, biologics, surgical dressings, supplies, splints, casts and appliances and equipment directly related to the provision of surgical procedures.
- Diagnostic or therapeutic services or items directly related to the provision of a surgical procedure.
- Administration, record keeping, and housekeeping items and services.
- Intraocular lenses.
- Materials for anesthesia.
- Blood, blood plasma and platelets.

ASC SERVICES NOT INCLUDED IN THE FACILITY PAYMENT

Facility payments for ASCs do not include the following services, which are paid separately:

- Professional services including physicians.
- Laboratory services.
- X-Ray or diagnostic procedures (other than those directly related to the performance of the surgical procedure).
- Prosthetics and Implants (except intraocular lenses).
- Ambulance services.
- Leg, arm, back and neck braces.
- Artificial limbs.
- Durable Medical Equipment (DME) for use in the patient's home.

ASC PROCEDURES COVERED FOR PAYMENT

The department will use the Centers for Medicare and Medicaid Services (CMS) list of procedures covered in an ASC plus additional procedures as determined by the department. All procedures covered in an ASC are listed in the *Medical Aid Rules and Fee Schedules, Ambulatory Surgery Center Fee Schedule* section.

The department has decided to expand the list that CMS established for allowed procedures in an ASC. There are three areas where the list has been expanded:

1. Labor & Industries will cover surgical procedures that other Washington State agencies cover in ASCs and that meet L&I's coverage policies.

2. Labor & Industries will cover surgical procedures that CMS covers in its hospital outpatient prospective payment system called Ambulatory Payment Classifications (APCs) that are not on the CMS ASC list and that meet L&I's coverage policies.
3. Labor & Industries will cover some procedures in an ASC that CMS covers only in an inpatient setting, if the following criteria are met:
 - a. The surgeon deems that it is safe and appropriate to perform such a procedure in an outpatient setting; and
 - b. The procedure meets the department's utilization review requirements.

ASC PROCEDURES NOT COVERED FOR PAYMENT

Procedures that are not listed in the *Ambulatory Surgery Center Fee Schedule* section of the *Medical Aid Rules and Fee Schedules* are not covered in an ASC.

ASCs will not receive payment for facility services for minor procedures that are commonly done in an office setting or treatment room. See below for exceptions to this policy. The professional performing such procedures may still bill for the professional component of such procedures.

Process to Obtain Approval for a Non-Covered Procedure

Under certain conditions, the director, the director's designee, or self-insurer, in their sole discretion, may determine that a procedure not on the department's ASC procedure list may be authorized in an ASC. For example, when a procedure could be harmful to a particular patient unless performed in an ASC. Requests for coverage under these special circumstances require prior authorization.

The health care provider must submit a written request and obtain approval from the department or self-insurer, prior to performing any procedure not on the ASC procedure list. The written request must contain a description of the proposed procedure with associated procedure codes, the reason for the request, the potential risks and expected benefits, and the estimated cost of the procedure. The healthcare provider must provide any additional information about the procedure requested by the department or self-insurer.

ASC BILLING INFORMATION

Modifiers accepted for ASCs

The SG modifier may accompany all CPT® and HCPCS codes.

The department will accept modifiers listed in the CPT® and HCPCS books including those listed as approved for ASCs. Only modifiers affecting payment are listed below:

-50 Bilateral surgery

Modifier -50 identifies cases where a procedure typically performed on one side of the body is performed on both sides of the body during the same operative session. Providers must bill using two line items on the bill form. The modifier -50 should be applied to the second line item. The second line item will be paid at 50% of the allowed amount for that procedure.

Example: Bilateral Procedure

| Line item on bill | CPT® code/modifier | Maximum payment (Group 2) | Bilateral policy applied | Allowed amount |
|-----------------------------|--------------------|---------------------------|--------------------------|----------------------|
| 1 | 64721- SG | \$1,130.28 | | \$1,130.28 (1) |
| 2 | 64721 – SG - 50 | \$1,130.28 | \$565.14 (2) | \$565.14 |
| Total allowed amount | | | | \$1695.42 (3) |

- Notes:
1. First line item is paid at 100% of maximum allowed amount.
 2. When applying the bilateral payment policy the second line item billed with a modifier -50 is paid at 50% of the maximum allowed amount for that line item.
 3. Represents total allowable amount.

-51 Multiple surgery

Modifier -51 identifies when multiple surgeries are performed on the same patient at the same operative session. Providers must bill using two line items on the bill form. The modifier -51 should be applied to the second line item. The total payment equals the sum of:

100% of the maximum allowable fee for the highest valued procedure according to the fee schedule.

50% of the maximum allowable fee for the subsequent procedures with the next highest values, according to the fee schedule.

Example: Multiple Procedures

| Line item on bill | CPT® code/modifier | Maximum payment (Groups 9 & 2) | Multiple policy applied | Allowed amount |
|-----------------------------|--------------------|--------------------------------|-------------------------|----------------------|
| 1 | 29881 – SG | \$2,107.75 | | \$2,107.75 (1) |
| 2 | 64721 – SG - 51 | \$1,130.28 | \$565.14 (2) | \$565.14 |
| Total allowed amount | | | | \$2672.89 (3) |

- Notes:
1. Highest valued procedure is paid at 100% of maximum allowed amount.
 2. When applying the multiple procedure payment policy the second line item billed with a modifier -51 is paid at 50% of the maximum allowed amount for that line item.
 3. Represents total allowable amount.

-73 Discontinued procedure prior to the administration of anesthesia

Modifier –73 is used when a physician cancels a surgical procedure due to the onset of medical complications subsequent to the patient’s preparation, but prior to the administration of anesthesia. Payment will be at **50%** of the maximum allowable fee. Multiple and bilateral procedure pricing will apply to this, if applicable.

-74 Discontinued procedure after administration of anesthesia

Modifier –74 is used when a physician terminates a surgical procedure due to the onset of medical complications after the administration of anesthesia or after the procedure was started. Payment will be at **100%** of the maximum allowable fee. Multiple and bilateral procedure pricing will apply to this, if applicable.

-99 Multiple modifiers

This modifier should only be used when two or more modifiers affect payment. Payment is based on the policy associated with each individual modifier that describes the actual services performed. For billing purposes, only modifier -99 should go in the modifier column, with the individual descriptive modifiers that affect payment listed in the remarks section of the billing form.

Implants

Implants should be billed on a separate line. The following HCPCS implant codes are covered by the department: L8500 through L8699. ASCs will be paid acquisition cost for implants.

Exception:

L8603 has a maximum fee and pays the lesser of the maximum fee or acquisition cost.

Exception:

Intraocular lenses, including new technology lenses, are bundled into the fee for the associated procedure. Please include the cost of the lens in the charge for the procedure. It is permissible to include a line on the bill with the HCPCS code for an intraocular lens (i.e. V2630, V2631, V2632) and its associated cost, for information purposes only.

Acquisition Costs Policy:

The acquisition cost equals the wholesale cost plus shipping, handling, and sales tax. These items should be billed together as one charge. For taxable items, an itemized listing of the cost plus sales tax may be attached to the bill, but is not required.

Wholesale invoices for all supplies and materials must be retained in the provider's office files for a minimum of five years. A provider must submit a hard copy of the wholesale invoice to the department or self-insurer when an individual supply costs \$150.00 or more, or upon request. The insurer may delay payment of the provider's bill if the insurer has not received this information.

Example: Procedure with Implant

| Line item on bill | CPT® code/modifier | Maximum payment (Group 9) | Allowed amount |
|-----------------------------|--------------------|-----------------------------|-----------------------|
| 1 | 29851- SG | \$2,107.75 | \$2,107.75 (1) |
| 2 | L8699 | \$150.00 (acquisition cost) | \$150.00 (2) |
| Total allowed amount | | | \$2,257.75 (3) |

- Notes:
1. Procedure is paid at 100% of maximum allowed amount.
 2. Represents the total of wholesale implant cost plus associated shipping, handling, and taxes.
 3. Represents total allowable amount.



Do not use the temporary “C” HCPCS codes, as that will cause the bill to be denied.

Spinal Injections

Injection procedures are billed in the same fashion as all other surgical procedures with the following considerations.

For purposes of multiple procedure discounting, each procedure in a bilateral set is considered to be a single procedure.

For injection procedures which require the use of radiographic localization and guidance, ASCs must bill for the technical component of the radiologic CPT® code (e.g. 76005 – TC) to be paid for the operation of a fluoroscope or C-arm. Maximum fees for the technical components of the radiologic codes are listed in the *Radiology* section of the *Medical Aid Rules and Fee Schedules*.

Example: Injection Procedures

| Line item on bill | CPT® code/modifier | Maximum payment (Groups 1) | Bilateral/Multiple policies applied | Allowed amount |
|-----------------------------|--------------------|----------------------------|-------------------------------------|-----------------------|
| 1 | 64470 – SG | \$843.10 | | \$843.10 (1) |
| 2 | 64470 – SG - 50 | \$843.10 | \$421.55 (2) | \$421.55 |
| 3 | 64472 – SG | \$843.10 | \$421.55 (3) | \$421.55 |
| 4 | 64472 – SG - 50 | \$843.10 | \$421.55 (2) | \$421.55 |
| 5 | 76005 –TC | \$65.66 | | \$65.66 (4) |
| Total allowed amount | | | | \$2,173.41 (5) |

- Notes:
1. Highest valued procedure is paid at 100% of maximum allowed amount.
 2. When applying the bilateral procedure payment policy the second line item billed with a modifier -50 is paid at 50% of the maximum allowed amount for that line item.
 3. The multiple procedure payment policy is applied to subsequent procedures billed on the same day and are paid at 50% of the maximum allowed amount for that line item.
 4. This is the fee schedule maximum allowed amount for the fluoroscopic localization and guidance.
 5. Represents total allowable amount.

ASC PAYMENTS FOR SERVICES

The department pays the lesser of the billed charge (the ASC's usual and customary fee) or the department's maximum allowed rate.

The department's rates are based on a modified version of the grouping system developed by Medicare for ASC services. Medicare's grouping system was originally intended to group procedures with similar resource use together into payment categories. The department has modified Medicare's grouping system to fit a workers' compensation population.

Surgical services have been divided into 9 payment groups, each with an associated maximum fee.

**ASC Maximum Allowable Fee
by Group Number**

| Group | Fee |
|--------------|------------|
| 1 | \$843.10 |
| 2 | \$1,130.28 |
| 3 | \$1,293.63 |
| 4 | \$1,596.63 |
| 5 | \$1,817.95 |
| 6 | \$2,107.75 |
| 7 | \$2,521.40 |
| 8 | \$2,481.80 |
| 9 | \$2,107.75 |

Some services that do not belong to a payment group have a maximum fee. Other allowed services that are not part of a payment group are paid on a "by report" basis.

Payment groups and rates for allowed procedures are listed in the Ambulatory Surgery Center Fee Schedule.

BRAIN INJURY REHABILITATION SERVICES

Only programs accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) may provide post-acute brain injury rehabilitation services for injured workers. These services require prior authorization. Follow-up care is included in the cost of the full day or half day program. This includes, but is not limited to telephone calls, home visits and therapy assessments. Refer to Provider Bulletins 98-02 and 98-04 for more information.

Non-hospital based programs must bill the following local codes:

| | | |
|-------|--|------------|
| 8950H | Comprehensive brain injury evaluation | \$3,612.95 |
| 8951H | Post-acute brain injury rehabilitation full day program, per day (minimum of 6 hours per day) | \$645.17 |
| 8952H | Post-acute brain injury rehabilitation half day program, per day (minimum 4 hours per day) | \$387.11 |

Hospital based programs must bill the following revenue codes:

| | | |
|-----|---|------------|
| 014 | Comprehensive brain injury evaluation | \$3,612.95 |
| 015 | Full day program, per day (minimum 6 hours per day) | \$645.17 |
| 016 | Half day program, per day (minimum 4 hours per day)..... | \$387.11 |

NURSING HOME, HOSPICE AND RESIDENTIAL CARE

NURSING HOME, HOSPICE AND RESIDENTIAL CARE

Only licensed nursing homes, hospice or other residential care providers will be paid.

Group homes and other residential care settings may be approved by the insurer on a case by case basis depending on the worker's needs. Assisted living is not a covered service.

Medically necessary skilled nursing care and custodial care are covered for the worker's accepted industrial injury or illness. Daily rate fees are negotiated between the facility and the insurer based on the Medicaid and Medicare rates for services provided. Occupational, physical and speech therapies are included in the daily rate and are not separately payable. Pharmacy and DME are payable when billed separately using appropriate HCPCS codes.

- 8902H Nursing home or residential care (group home or boarding home)..... BR
- 8906H Facility hospice care BR

